South Africa Demographic and Health Survey 2003

Preliminary Report

Department of Health
Pretoria, South Africa

MEASURE DHS
ORC Macro
Calverton, Maryland, USA

SOUTH AFRICA
DEMOGRAPHIC AND HEALTH SURVEY
2003

PRELIMINARY REPORT

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KEY FINDINGS OF THE SURVEY

Mortality rates

Infant mortality rate: 43 per 1,000 live births

Under-5 mortality rate: 58 per 1,000 live births

Child mortality rate: 16 per 1,000 live births

Percent of children 12-23 months with vaccination cards: 68

Exclusive breastfeeding (% of infants)
0-3 months: 12
4-6 months: 1.5
Not being breastfed 0-3 months: 20.1

Heard of AIDS (% of men 15-49): 95; (% of women 15-49): 94

Knowledge about AIDS (% of men 15-59 and women 15-49)

People can reduce chances of getting HIV and AIDS by using condoms: 85 (men); 71 (women)
People can reduce chances of getting HIV and AIDS by having just one uninfected, faithful partner: 82 (men); 75 (women)

Condom use (% of sexually active women 15-49)
Ever used condom: 39
Used condom at last sex: 33

Total fertility rate: 2.0 children per woman

Modern contraceptive prevalence rate:
Married women aged 15-49: 60
Sexually active women aged 15-49: 65

Antenatal care from doctor/nurse (% of most recent births in last five years): 92

Assistance during delivery (% of births in last 5 years)
Doctor: 27
Nurse/midwife: 65

Smoking rate (% of adults age 15+)
Men: 31
Women: 8
Adolescents (15-19): 10

Prevalence of symptoms of asthma (% of adults age 15+)
Men: 8
Women: 9

Prevalence of symptoms associated with chronic bronchitis (% of adults age 15+)
Men: 2
Women: 2

Overweight (% of adults age 15+)**
Men: 29
Women: 59

Obesity (% of adults age 15+)
Men: 8
Women: 23

* Received BCG, three doses of DPT and polio, and measles vaccines.
** Includes those who are obese

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FOREWORD

The South African Demographic and Health Survey (SADHS) 2003 is the second survey of its kind to be carried out in South Africa. The survey enables us to assess 5 year trends in relation to the health status of our population, risk factors, coverage, access and utilisation of key health services.

The preliminary results of the SADHS highlight critical areas such as child health, health care for mothers during pregnancy and at the time of delivery, infant feeding practices, child immunisation coverage, and the prevalence and treatment of diarrhoeal disease among children. It also provides information on women's reproductive intentions, fertility levels, contraceptive knowledge and use and adult health conditions.

Information collected in the 2003 SADHS will be instrumental in reviewing and consolidating interventions for health programmes in South Africa and for general health monitoring as well as monitoring the Millennium Development Goals for South Africa.

I need to express my greatest appreciation for the collaboration from the Department of Social Development and Statistics South Africa as this information will inform our departmental policies and interventions, and identify gaps in our systems that would need further attention. It is my hope that these findings will assist government to fulfil its mandate of improving the health and social well-being of our population and to determine how resources are distributed and managed to address the gaps identified by this report.

DR M E TSHABALALA-MSIMANG
MINISTER OF HEALTH

ACKNOWLEDGEMENTS

The 2003 South African Demographic and Health Survey (SADHS) is a project, which was initiated and funded by the National Department of Health. In its implementation, several organisations and numerous individuals put a great deal of effort into ensuring that the project was conducted to the best of our abilities.

I would like to acknowledge the ongoing support of the MECs and Provincial Heads of Health Departments and all staff of the Department of Health who participated in the drafting of the questionnaires, and the Cluster responsible for co-coordinating the survey.

I would like to thank Ms P Netshidzivhani, Director: Research & Epidemiology, Mr B Kgweedi for administrative support for the project, Ms M Ratsaka-Mothokoa, Ms L Mahlasela, Ms C Molomo who was seconded from Statistics South Africa during the initial stages of the SADHS. Thanks to Africa Strategic Research Corporation, especially Dr Chimere-Dan for conducting the fieldwork and the Human Sciences Research Council's Mr Johan van Zyl for the data processing and analysis and Dr Debbie Bradshaw of the Medical Research Council for support in developing instruments.

In particular I would like to thank Dr L Makubalo, Project Director and Chief Director: Health Information, Evaluation and Research, Mr P Sekwati and Ms R du Plessis, Project co-ordinator.

The Department acknowledges efforts of members of the project management committee, the project technical team and all the technical consultants to the project for their contributions to the project, in particular representatives from the Departments of Social Development and Statistics South Africa, Reproductive Health Research Unit, Medical Research Council, University of Stellenbosch, ORC MACRO of Calverton, Maryland for providing technical assistance to the project as part of its international Demographic and Health Surveys programme, and the United States Agency for International Development (USAID)/South Africa for financial and technical assistance to the project.

MR. THAMSANQA MSELEKU
DIRECTOR-GENERAL: HEALTH

I BACKGROUND

A. Introduction

The 2003 South Africa Demographic and Health Survey (SADHS) was carried out by Africa Strategic Research Corporation (ASRC) under contract to the Department of Health (DOH). Data collection took place from mid-October 2003 to August 2004 in almost 8,000 households.

The 2003 SADHS was designed to provide data to monitor the population and health situation in South Africa. Thus, most of the information collected in the survey represents updated estimates of basic demographic and health indicators covered in the 1998 SADHS. Specifically, the 2003 SADHS collected information on fertility levels, marriage, sexual activity, fertility preferences, awareness and use of family planning methods, breastfeeding practices, nutritional status of adults and young children, childhood mortality, maternal and child health, awareness and behaviour regarding HIV and AIDS and other sexually transmitted infections, chronic health conditions of adults, habits of lifestyle that affect health, and prescribed medications taken by adults. In addition, various anthropometric measurements were taken for adults, such as height, weight, waist and hip circumference, blood pressure, and pulmonary flow. New areas in the 2003 SADHS include a survey of a subsample of men and the introduction of a questionnaire for children under age six who do not live with their biological mothers. Unlike the 1998 SADHS, the 2003 survey includes height and weight for children under age 5.

This report presents the preliminary results for selected key indicators covered in the survey. A more comprehensive and detailed report is scheduled to be published in mid-2005. The final figures are not expected to differ substantially from the findings presented in this preliminary report; however, the results presented here should be regarded as provisional.

B. Sample Design

The 2003 SADHS utilised a nationally-representative sample of over 10,000 households that was selected from the 2001 census data. As in the 1998 survey, an important objective of the 2003 survey is to produce results separately for each of the country's nine provinces, as well as for the four main racial groups. Due to the small percentage of the Indian/Asian population, areas with predominantly Indian/Asian households were oversampled. Thus, 10 strata were formed, one for each of the nine provinces and one consisting of all census enumeration areas (EAs) in which a minimum of 80 percent of the population were identified as Indian/Asian. Approximately 1,000 households were allocated to each stratum. As a result of these differing sample proportions, the SADHS sample is not self-weighting at the national level and weighting factors have been applied to the data in this report. In the 1998 survey, the Eastern Cape Province was markedly oversampled to provide regional level data, after obtaining additional funding.

The survey utilised a two-stage design. The first stage consisted of selecting census enumeration areas (EAs) as primary sampling units, with probability proportional to size based on the number of households in the EA. A total of 630 EAs was selected for the 2003 SADHS (368 in urban areas and 262 in non-urban areas). Sampling experts at Statistics South Africa assisted in the sample design and selected the primary sampling units, according to the specifications developed. Fieldwork was not implemented in 9 sample points.

The second stage of selection involved the systematic sampling of households/stands from the selected EAs. Funds were insufficient to allow implementation of a household listing operation in selected EAs. Fortunately, most of the country is covered by aerial photographs, which Statistics South Africa has used to create EA-specific photos. Using these photos, ASRC identified the global positioning system (GPS) coordinates of all the plots located within the boundaries of the selected EAs and selected 16 in each EA, for a total of 10,080 selected. The GPS coordinates provided a means of uniquely identifying the selected plot.

All women aged 15-49 years who were either permanent residents of the households in the sample or visitors present in the household on the night before the survey were eligible to be interviewed in the survey. In every second household selected for the survey, all men aged 15-59 years were also eligible to be interviewed. In the households not selected for the men's survey, all adults aged 15 and over were eligible to be interviewed with the adult health questionnaire.

C. Questionnaires

Five types of questionnaires were used for the SADHS: a Household Questionnaire, a Women's Questionnaire, a Men's Questionnaire, an Adult Health Questionnaire, and an Additional Child's Questionnaire. The contents of the first three questionnaires were based on the DHS Model Questionnaires. These model questionnaires were adapted for use in South Africa during a series of meetings with a Project Team that consisted of representatives from the National Department of Health, the Medical Research Council, the Human Sciences Research Council, Statistics South Africa, National Department of Social Development and ORC Macro. Draft questionnaires were circulated to other interested groups, e.g., University of Stellenbosch. The Additional Child's and Men's Questionnaires were developed to address information needs identified by stakeholders, e.g., information on why children are not staying with their biological mothers. All questionnaires were developed in English and then translated into and printed in all 11 official languages in South Africa (English, Afrikaans, isiXhosa, isiZulu, Sesotho, Setswana, Sepedi, SiSwati, Tshivenda, Xitsonga, and isiNdebele).

The Household Questionnaire was used to list all the usual members and visitors in the selected households. Some basic information was collected on the characteristics of each person listed, including his/her age, sex, education, and relationship to the head of the household. The main purpose of the Household Questionnaire was to identify persons who were eligible for individual interviews. In addition, information was collected about the dwelling itself, such as the source of water, type of toilet facilities, materials used to construct the house, and ownership of various consumer goods.

The Women's Questionnaire was used to collect information from women aged 15-49 in all households. These women were asked questions on the following topics:

- Background characteristics (age, education, race, residence, marital status, etc.)
- Reproductive history
- Knowledge and use of contraceptive methods
- Antenatal, delivery, and postnatal care
- Breastfeeding and weaning practices
- Child health and immunisation
- Marriage and recent sexual activity
- Fertility preferences

- Adult and maternal mortality
- Knowledge of HIV and AIDS
- Husband's background and respondent's work.

In every second household, in addition to the women, all men aged 15-59 were eligible to be interviewed. The Men's Questionnaire collected similar information contained in the Woman's Questionnaire, but was shorter because it did not contain questions on reproductive history, maternal and child health, nutrition, and maternal mortality.

In those households not selected for the Men's Questionnaire, all men and women age 15 and over were eligible to be interviewed with the Adult Health Questionnaire. The respondents were asked questions on:

- Recent utilisation of health services
- Family medical history
- Clinical conditions
- Dental health
- Occupational health
- Medications taken
- Habits and lifestyle
- Anthropometric measurements (height, weight, blood pressure, etc.).

Finally, in households in which there was a child under six years of age whose biological mother was either not alive or did not live in the household, information about the child was collected from a guardian using the Additional Child's Questionnaire. The reason for this is that the level of child fostering is relatively high in South Africa and data on children's health collected only from biological mothers might result in biased information.

The SADHS questionnaires were pre-tested in July 2003, using the "behind the glass"[1] technique, in two languages. The questionnaires were then adapted to take into account the suggested changes for questions that were misunderstood or were not clear. Subsequently, four teams of interviewers (one for each of four main language groups) were formed; and each team did a testing of the household, male, female and adult health questionnaires. The lessons learnt from the two exercises were used to finalise the survey instruments and logistical arrangements for the survey.

D. Training

The Department of Health issued a tender for the implementation of the field work for the survey. The contract was awarded to Africa Strategic Research Corporation (ASRC), a private firm based in Johannesburg. ASRC organised a 2-week training course from September 15-30 2003 at a centre outside of Pretoria. At this training, 125 candidates were trained as interviewers

[1] This refers to a process in which interviewers interview respondents using the questionnaires, being observed by a team of experts, from behind a one-way window. The experts are not visible to the interviewer/interviewee. Once the interview is finalised, it is discussed by the interviewer, respondent, and the team of experts to determine if any questions were not clear, etc. Changes to the questions are then suggested.

and supervisors. Trainers consisted of personnel from the Medical Research Council, the Human Sciences Research Council (HSRC), the DOH, and ORC Macro, as well as staff and consultants hired by ASRC. Training consisted mainly of plenary sessions on interviewing techniques, survey administration, and explaining the questionnaire and how to complete it, as well as smaller sessions to practise the anthropometric measurements and interviewing in local languages. The training included mock interviews between participants and two written tests. A practise session was arranged one Saturday to give trainees experience with interviewing actual households living around Pretoria and Johannesburg.

ASRC was unable to recruit a sufficient number of interviewers of the required racial and gender groups for the first training. Consequently, a second training for an additional 49 trainees was arranged for October 6-11. In order to further balance the ethnic group and gender composition of the teams as well as to make up for attrition of field staff, some additional fieldworkers were trained in February 2004.

E. Fieldwork

Fieldwork for the 2003 SADHS was carried out by about 192 field staff, organised into teams consisting of varying numbers of female and male interviewers and headed by a supervisor. In each province, there was a provincial manager who was an overall supervisor of the fieldwork operations. Staff from HSRC and the DOH conducted periodic quality control visits during fieldwork. Fieldwork commenced in mid-October 2003 and was completed in August 2004.

F. Data Processing

Preliminary processing of the SADHS questionnaires began in November so as to provide some feedback to field teams. The actual data processing did not start until January 2004, after a contract was arranged with the HSRC in Pretoria. Completed questionnaires were returned periodically from the field to ASRC, which in turn submitted them to HSRC, where they were entered and edited by data processing personnel specially trained for this task. Data were entered using CSPro. All data were entered twice (100 percent verification). The data processing of the survey was completed in October 2004.

G. Response Rates

Table 1 shows response rates for the 2003 SADHS. A total of 10,214 households were selected in the sample, of which 9,181 were found occupied at the time of the fieldwork. The shortfall is largely due to structures that were found to be vacant or destroyed. Of the existing households, 7,756 were interviewed, yielding a household response rate of 85 percent.

In the households interviewed in the survey, a total of 7,966 eligible women were identified, of whom 7,041 were interviewed, yielding a response rate of 88 percent. With regard to the male survey results, 3,930 eligible men were identified in the sub-sample of households selected for the male survey, of whom 3,118 were interviewed, yielding a response rate of 79 percent. As for adults, 8,115 were interviewed out of 9,614 eligible, for a response rate of 84 percent.

The principal reason for non-response at all levels was refusal, followed by the failure to find individuals at home. Eleven percent of households, 6 percent of women, 10 percent of men, and 7 percent of adults refused to be interviewed.

Table 1 Response rates, South Africa 2003

Households	
Households selected	10,214
Households occupied	9,181
Households interviewed	7,756
Household response rate	84.5
Women's interviews	
Number of eligible women	7,966
Number of women interviewed	7,041
Eligible women response rate	88.4
Men's interviews	
Number of eligible men	3,930
Number of men interviewed	3,118
Eligible men response rate	79.3
Adults' interviews	
Number of eligible adults	9,614
Number of adults interviewed	8,115
Eligible adult response rate	84.4

H. Characteristics of Respondents

The distribution of women aged 15-49 years and men aged 15-59 years by background characteristics is shown in Table 2. The proportions of both women and men decline gradually with increasing age, reflecting the effects of past above-replacement level fertility as well as the effects of mortality.

Table 2 Background characteristics of women 15-49 and men 15-59

Percent distribution of women aged 15-49 and men aged 15-59 by background characteristics, South Africa 2003

Background characteristic	Women			Men		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15-19	19.7	1,384	1,450	19.0	592	649
20-24	17.6	1,239	1,227	16.8	525	517
25-29	14.4	1017	1,019	13.6	424	397
30-34	13.1	925	901	11.1	347	334
35-39	14.2	997	972	11.0	341	338
40-44	11.6	817	782	10.4	326	292
45-49	9.4	662	690	7.2	226	233
50-54	na	na	na	5.9	185	197
55-59	na	na	na	4.9	152	161
Residence						
Urban	69.2	4,871	4,095	72.4	2,259	1874
Rural	30.8	2,170	2,946	27.6	859	1,244
Province						
Western Cape	12.8	899	715	12.0	373	237
Eastern Cape	10.7	750	505	9.4	294	192
Northern Cape	1.8	130	777	1.8	57	374
Free State	6.6	465	796	6.2	193	361
KwaZulu-Natal	18.6	1,311	1,219	25.5	796	702
North West	7.6	538	749	6.5	201	330
Gauteng	25.6	1,801	722	25.8	804	346
Mpumalanga	6.3	444	776	6.3	195	346
Limpopo	10.0	701	782	6.6	205	230
Education						
No education	4.2	295	337	4.4	136	170
Grades 1-5	6.1	428	497	7.0	217	252
Grades 6-7	10.1	714	790	9.7	303	349
Grades 8-11	46.4	3,269	3,263	43.8	1,365	1,358
Grade 12	24.4	1,716	1,555	26.1	814	699
Higher	8.8	620	599	9.1	284	290
Population group						
African	82.4	5,801	5,234	81.0	2,525	2,327
Coloured	9.7	682	933	8.6	269	348
White	5.9	415	274	8.0	251	156
Asian	2.0	141	596	2.2	68	282
Total	100.0	7,041	7,041	100.0	3,118	3,118

Note: Education categories refer to the highest level of education completed. The table is based on de facto population enumerated in the women's and men's questionnaire.
na = Not applicable

The analysis shows that seven in ten women and men live in urban areas. One-quarter of the respondents live in Gauteng Province. There are differences in the distribution by province between women and men, with one-quarter of men living in KwaZulu-Natal Province, compared to less than one-fifth of women. Conversely, a larger proportion of women than men live in Limpopo Province.

Only 4 percent of women and men interviewed have no education, while one in four have completed grade 12 only and 9 percent have gone beyond high school. Over 80 percent of respondents are African, while about 9 percent are Coloured, 7 percent are White and only 2 percent are Asian.

The distribution of adults interviewed is shown in Table 3 and is similar to that of women and men except that adults tend to be slightly less urbanised and less educated than those in the reproductive ages.

Table 3 Background characteristics of adults interviewed (Adult Health)

Percent distribution of adult women and men by background characteristics, South Africa 2003

Background characteristic	Adult women 15+			Adult men 15+		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15-24	26.7	1,248	1,284	32.8	1,130	1,090
25-34	21.4	998	984	21.1	727	684
35-44	18.4	860	841	17.5	601	563
45-54	14.8	694	747	12.6	433	425
55-64	9.9	464	488	8.6	295	299
65+	8.8	410	443	7.4	254	267
Residence						
Urban	66.9	3,129	2,694	70.0	2,408	1,947
Rural	33.1	1,546	2,093	30.0	1,033	1,381
Province						
Western Cape	12.5	583	406	10.0	344	243
Eastern Cape	11.6	540	393	10.3	354	251
Northern Cape	1.9	91	552	1.7	59	362
Free State	6.7	312	545	6.5	223	393
KwaZulu-Natal	20.5	956	909	24.7	851	731
North West	7.6	355	509	6.9	238	335
Gauteng	23.0	1,074	432	26.6	914	370
Mpumalanga	6.1	286	515	5.8	200	359
Limpopo	10.2	477	526	7.5	259	284
Education						
No education	11.9	554	677	8.4	288	340
Grades 1-5	9.4	438	507	9.5	328	351
Grades 6-7	10.5	493	570	10.9	375	424
Grades 8-11	40.2	1,879	1,842	39.8	1,370	1,323
Grade 12	20.0	937	842	21.2	730	613
Higher	8.0	374	349	10.2	351	277
Population group						
African	81.0	3,787	3,509	82.3	2,832	2,531
Coloured	9.5	446	618	7.5	259	343
White	6.1	283	185	6.8	234	122
Asian	2.1	100	418	2.2	76	302
Total	100.0	4,674	4,787	100.0	3,441	3,328

Note: Education categories refer to the highest level of education completed. The table is based on de facto population enumerated in the adult health questionnaire.

II. REPRODUCTIVE HEALTH

A. Fertility

Fertility data were collected in the survey by asking each of the women interviewed for a history of her pregnancies. The information obtained on each of the woman's live births included the month and year of the birth. These data are used to calculate two of the most widely used measures of current fertility, the total fertility rate (TFR) and its component age-specific fertility rates.

Table 4 Current fertility

Age-specific and total fertility rates (TFR) and the crude birth rate (CBR) for the three years preceding the survey, by urban-rural residence, South Africa 2003

	Residence		
Age group	Urban	Rural	Total
15-19	55	53	54
20-24	103	97	101
25-29	100	86	96
30-34	84	76	82
35-39	45	75	53
40-44	12	30	17
45-49	6	7	6
TFR	2.0	2.1	2.0
CBR	18.1	15.9	17.3

Note: Rates for age group 45-49 may be slightly biased due to truncation.

As indicated in Table 4, the total fertility rate is 2.0 for the three-year period prior to the survey (approximately centered on mid-2002). This means that on average, a South African woman who is at the beginning of her childbearing years will give birth to 2.0 children by the end of her reproductive period if fertility levels remain constant at the level observed in the three-year period before the survey.

The TFR in rural areas (2.1 births) is insignificantly higher than the rate in urban areas (2.0 births). The results also show that urban rates are higher than rural rates at the younger ages and lower than rural rates at older ages.

The results imply a precipitous decline in South Africa's fertility over the previous five years. The total fertility rate for the three-year period prior to the 1998 SADHS was 2.9 (DOH, no date). Other recent estimates of the total fertility rate at the national level range from 2.8 to 3.3 (SSA, 2004; Udjo, 2003). A more detailed analysis of the SADHS fertility data is necessary to explore how much of the apparent decline in fertility is real and how much is due to underreporting of births.

Table 5 shows fertility data by background characteristics. The TFR for KwaZulu-Natal Province (0.6) is particularly low, almost certainly implying underreporting of births. When KwaZulu-Natal is omitted from the tabulation, the national TFR rises from 2.0 to 2.4. Fertility is relatively low in Free State, Eastern Cape, Gauteng and Mpumalanga Provinces. It is highest in Northern Cape and Limpopo.

The total fertility rate reported for Africans (2.1) is slightly lower than that for coloureds (2.3). The TFR among the Asian group is 1.6. Unfortunately, the number of white women interviewed was too small to provide a reliable measure of the total fertility rate.

Table 6 shows that 12 percent of teenaged women (age 15-19) have ever been pregnant, while 9 percent have given birth. This is a decline from the level of 16 percent ever pregnant and 13 percent mothers, as reported in the 1998 SADHS. The levels are surprisingly low for KwaZulu-Natal; however, they have also declined substantially in Mpumalanga and Limpopo since 1998.

Table 5 Fertility by background characteristics

Total fertility rate for the three years preceding the survey, percentage of women 15-49 currently pregnant, and mean number of children ever born to women age 40-49 years, by background characteristics, South Africa, 2003

Background characteristic	Total fertility rate[1]	Percentage currently pregnant[1]	Mean number of children ever born to women age 40-49
Residence			
Urban	2.0	2.8	3.0
Rural	2.1	3.9	3.8
Province			
Western Cape	2.6	3.5	3.0
Eastern Cape	(2.2)	3.3	3.8
Northern Cape	2.8	3.5	3.2
Free State	(2.0)	3.6	3.3
KwaZulu-Natal	0.6	2.7	2.3
North West	(2.5)	3.9	3.5
Gauteng	2.3	2.8	3.1
Mpumalanga	(2.3)	2.4	3.7
Limpopo	2.7	4.0	4.4
Education			
No education	*	2.9	4.4
Grades 1-5	*	1.9	3.6
Grades 6-7	2.5	3.0	3.6
Grades 8-11	2.2	3.1	3.1
Grade 12	1.5	3.7	2.3
Higher	(1.8)	2.8	2.6
Population group			
African	2.1	3.4	3.4
Coloured	2.3	3.0	2.9
White	*	1.2	2.2
Asian	1.6	1.9	2.4
Total	2.0	3.2	3.2

Note: Numbers in parentheses represent TFRs for which one or more of the component age-specific rates is based on 125-249 unweighted woman-years of exposure. An asterisk indicates a rate based on fewer than 125 woman-years of exposure that has been suppressed.
[1] Women age 15-49 years

Table 6 Adolescent pregnancy and motherhood

Percentage of women age 15-19 who have given birth or who have been pregnant by background characteristics, South Africa 2003

Background characteristic	Mothers	Ever pregnant	Number of women
Age			
15	1.1	1.9	294
16	3.3	5.2	275
17	9.6	11.4	272
18	11.9	15.6	295
19	22.9	27.3	247
Residence			
Urban	8.7	10.9	859
Rural	10.6	13.5	525
Province			
Western Cape	10.4	14.3	164
Eastern Cape	7.3	13.6	172
Northern Cape	12.3	16.1	28
Free State	12.2	15.4	100
KwaZulu-Natal	2.0	2.0	261
North West	10.6	14.3	97
Gauteng	11.2	12.3	269
Mpumalanga	12.1	13.1	91
Limpopo	14.0	16.8	201
Education			
No education	*	*	8
Grades 1-5	(5.3)	(9.5)	32
Grades 6-7	16.2	20.0	117
Grades 8-11	8.9	11.4	1,019
Grade 12	7.3	9.0	182
Higher	(6.9)	(6.9)	26
Population group			
African	10.2	12.5	1,199
Coloured	6.4	11.7	114
White	(0.0)	(2.4)	51
Asian	2.2	2.2	20
Total	9.4	11.9	1,384

Note: Numbers in parentheses are based on fewer than 25 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

B. Fertility Preferences

Questions in the survey concerning women's fertility preferences included: a) whether the respondent wanted another child and b) if so, when she would like to have the next child. The answers to these questions allow for the estimation of the potential demand for family planning services either to limit or space births.

Figure 1 shows that there is widespread desire among South African women to control the timing and number of births. Among all currently married women, 61 percent either do not want to have another child or are sterilised and 9 percent would like to wait for two years or more for the next birth. Twelve percent of married women would like to have a child soon (within two years). The remainder are uncertain about their fertility desires or say they are unable to get pregnant (infecund).

Figure 1
Fertility Preferences among Currently Married Women, South Africa 2003-2004

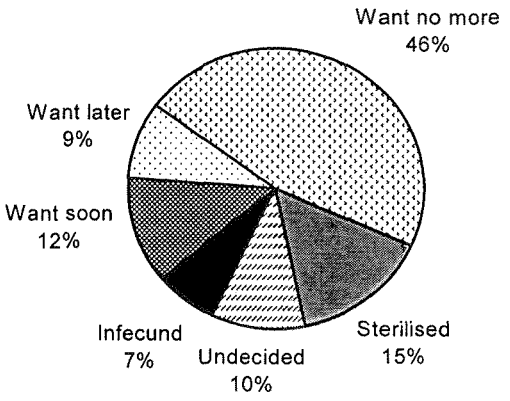


Table 7 shows that fertility preferences are closely related to the number of living children a woman has. Two in five currently married women without a child (40 percent) would like to have one soon. Women show greater interest in controlling the pace of childbearing once they have a child. The proportion wanting no more children or sterilised rises from 36 percent among women with one living child to 87 percent of women with six or more living children.

There has been some change in fertility preferences among married women since 1998. The proportion that wants to have another child soon has declined slightly (from 16 to 12 percent), as has the proportion that wants another child later (from 12 to 9 percent). The proportion of married women who either want no more children or have been sterilised has remained stable (62 percent in 1998 and 61 percent in 2003), while the percentage who say they are unable to have another child has increased from 3 percent in 1998 to almost 7 percent in 2003.

Table 7 Fertility preferences by number of living children

Percent distribution of currently married women by desire for children, according to number of living children, South Africa, 2003

	Number of living children[1]							
Desire for children	0	1	2	3	4	5	6+	Total
Have another soon[2]	40.0	17.0	10.3	4.0	3.1	3.2	1.1	11.6
Have another later[3]	10.1	19.5	6.7	5.3	2.6	1.3	0.5	8.6
Have another, undecided when	4.9	5.8	2.5	1.5	1.2	1.0	0.0	2.4
Undecided	13.6	8.5	5.0	6.5	6.8	5.1	4.7	7.1
Want no more	12.7	31.2	51.6	51.9	57.1	62.8	65.0	45.5
Sterilised[4]	2.3	4.4	14.5	23.6	23.5	23.3	21.5	15.1
Infecund	10.7	9.7	7.8	4.5	3.0	1.5	4.5	6.7
Missing	5.6	4.0	1.6	2.9	2.7	1.8	2.7	3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	265	527	700	603	300	139	117	2,650

[1] Includes current pregnancy
[2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years
[4] Includes both male and female sterilisation

C. Contraceptive Use

Information about knowledge and use of contraceptive methods was collected from female respondents by asking them to mention any ways or methods by which a couple can delay or avoid a pregnancy. For each method known, the respondent was asked if she had ever used it. Respondents reporting ever use of family planning were asked whether they or their partner was using a method at the time of the survey.

Table 8 shows the level of knowledge, ever use and current use of specific contraceptive methods among all women, currently married women and sexually active women. Contraceptive methods are grouped into two types in the table, namely modern and traditional methods. Modern methods include female and male sterilisation, pill, IUD, injectables, implants, diaphragm/foam/jelly, male condom, and female condom. Traditional methods include periodic abstinence (rhythm method), withdrawal, and folk/other methods.

Table 8 Knowledge, ever use and current use of contraceptive methods

Percentage of all women, currently married women, and sexually active women knowing of, ever using, and currently using contraceptive methods, South Africa, 2003

	Percent who know			Percent who ever used			Percent currently using		
Contraceptive method	All	CM	SA	All	CM	SA	All	CM	SA
Any method	93.7	95.8	96.5	70.7	82.9	85.7	50.6	60.3	65.3
Any modern method	93.6	95.7	96.5	70.2	82.3	85.2	50.5	60.3	65.2
Pill	78.2	82.3	81.6	23.2	30.7	29.2	9.1	11.1	12.5
IUD	40.3	50.2	48.1	3.8	6.1	4.9	0.6	1.0	0.8
Injectables	84.7	87.3	88.3	47.2	52.7	56.1	26.9	28.4	33.2
Diaphr./Foam/Jelly	9.8	13.4	11.7	0.5	0.8	0.6	0.0	0.0	0.0
Male condom	80.2	80.1	82.8	30.1	28.5	39.2	6.1	4.7	7.9
Female condom	54.1	54.9	57.0	2.6	1.8	3.1	0.3	0.0	0.3
Female sterilisation	45.5	56.2	49.8	7.3	14.4	10.0	7.3	14.4	10.0
Male sterilisation	28.8	37.4	32.8	0.7	1.4	1.1	0.3	0.7	0.5
Implants	9.3	12.5	10.8	0.2	0.1	0.2	0.0	0.0	0.0
Any traditional method	32.6	38.2	38.3	8.9	10.3	11.4	0.1	0.0	0.0
Lactational amenor.	9.9	13.4	11.7	1.3	2.0	1.7	0.1	0.0	0.0
Periodic abstinence	15.9	20.3	19.1	2.1	2.4	2.6	0.0	0.0	0.0
Withdrawal	22.2	27.4	27.9	4.7	5.9	6.4	0.0	0.0	0.0
Other methods	20.9	23.5	24.5	3.0	2.8	3.9	0.0	0.0	0.0
Number of women	7,041	2,650	3,315	7,041	2,650	3,315	7,041	2,650	3,315

CM= currently married women
SA= sexually active in the four weeks preceding the survey

The data show that there has been a decline in the level of knowledge of contraceptive methods since 1998. For example, in 1998, 68 percent of all women had heard of female sterilisation, compared to 46 percent in 2003. There has also been a decline in the proportion of women who have ever used contraception, from 75 percent in 1998 to 71 percent in 2003 among all women and from 85 percent to 83 percent among currently married women.

More than half of currently married women (60 percent) are currently using some method of contraception, as are two-thirds (65 percent) of women who were sexually active in the month prior to the survey. Modern methods of contraception are almost exclusively used; less than one-tenth of one percent of women rely on traditional methods. Of the modern methods, injectables are by far the most widely used.

Trends since 1998 in current contraceptive use are mixed. Current use has remained constant for all women (from 50 percent in 1998 to 51 percent in 2003) and increased among currently married women (from 56 percent to 60 percent) and women who reported having been sexually active in the month prior to the survey (from 62 percent in 1998 to 65 percent in 2003).

As shown in Table 9, contraceptive use is slightly higher among younger sexually active women and those living in urban areas, but the differences are not strong. Use is highest in KwaZulu-Natal (77 percent) and lowest in Limpopo Province (59 percent). The strongest differences appear with education; contraceptive use rises markedly as education of the woman increases. It also increases with the number of children up to 3. Use is highest among White and Asian women and lowest among African women.

Table 9 Current use of contraception by background characteristics

Percent distribution of sexually active women (in the 4 weeks before the survey) by contraceptive method currently being used, according to background characteristics, South Africa 2003

Background characteristic	Any method	Any modern method	Pill	IUD	Inject-ables	Male con-dom	Female con-dom	Female sterili-sation	Male sterili-sation	Any tradi-tional method	Not cur-rently using	Total	Num-ber
Age group													
15-19	68.1	68.1	5.5	1.4	43.7	17.3	0.0	0.0	0.2	0.0	31.9	100.0	250
20-24	68.8	68.8	12.5	0.0	41.1	14.7	0.2	0.4	0.0	0.0	31.2	100.0	549
25-29	66.0	65.9	18.5	0.5	36.7	7.8	0.4	1.9	0.1	0.1	34.0	100.0	552
30-34	64.9	64.9	18.5	0.4	34.5	4.1	0.1	7.1	0.0	0.0	35.1	100.0	569
35-39	65.2	65.2	11.9	1.3	31.4	4.5	0.4	14.9	0.9	0.0	34.8	100.0	612
40-44	64.4	64.4	7.2	2.2	25.7	5.9	0.6	20.8	1.9	0.0	35.6	100.0	472
45-49	57.5	57.5	5.8	0.0	16.7	5.1	0.0	29.0	0.9	0.0	42.5	100.0	310
Residence													
Urban	66.2	66.2	13.1	1.1	31.2	7.9	0.3	11.8	0.7	0.0	33.8	100.0	2,410
Rural	62.7	62.7	10.9	0.2	38.3	7.9	0.1	5.2	0.1	0.1	37.3	100.0	905
Province													
Western Cape	63.1	63.1	13.7	0.3	23.1	2.8	0.0	21.3	1.9	0.0	36.9	100.0	424
Eastern Cape	63.7	63.7	8.6	0.0	39.9	6.8	1.6	6.8	0.0	0.0	36.3	100.0	289
Northern Cape	60.1	60.1	9.1	0.4	28.9	6.8	0.0	14.9	0.0	0.0	39.9	100.0	52
Free State	59.7	59.7	13.0	0.7	30.9	6.9	0.0	8.1	0.0	0.0	40.3	100.0	177
KwaZulu-Natal	77.0	77.0	14.3	0.9	43.0	10.8	0.0	7.5	0.5	0.0	23.0	100.0	674
North West	60.9	60.9	13.0	0.4	31.5	9.2	0.0	6.8	0.0	0.0	39.1	100.0	239
Gauteng	63.1	63.1	12.9	1.2	29.8	7.8	0.3	10.4	0.6	0.0	36.9	100.0	945
Mpumalanga	62.7	62.4	12.1	0.7	31.7	8.5	0.3	8.7	0.5	0.2	37.3	100.0	228
Limpopo	59.4	59.4	9.4	1.4	34.2	8.9	0.3	5.2	0.0	0.0	40.6	100.0	287
Education													
No education	37.9	37.9	4.6	0.0	19.2	4.0	0.5	9.6	0.0	0.0	62.1	100.0	163
Grades 1-5	51.7	51.7	4.7	1.5	33.2	1.4	0.0	10.9	0.0	0.0	48.3	100.0	192
Grades 6-7	59.9	59.9	7.7	0.3	36.6	2.8	0.0	12.6	0.0	0.0	40.1	100.0	325
Grades 8-11	63.3	63.3	8.4	0.4	35.9	8.2	0.5	9.4	0.5	0.0	36.7	100.0	1,376
Grade 12	73.9	73.9	18.9	1.3	34.7	9.2	0.1	9.1	0.6	0.1	26.1	100.0	899
Higher	75.2	75.2	24.3	1.7	22.3	13.0	0.0	12.3	1.6	0.0	24.8	100.0	361
Population group													
African	62.8	62.8	10.1	0.7	36.7	8.6	0.3	6.2	0.0	0.0	37.2	100.0	2,661
Coloured	70.2	70.2	15.3	0.8	29.2	1.7	0.0	21.0	2.1	0.0	29.8	100.0	305
White	81.1	81.1	27.6	2.1	9.6	8.6	0.0	29.8	3.3	0.0	18.9	100.0	263
Asian	75.3	75.3	30.2	1.8	9.4	4.3	0.2	28.2	1.2	0.0	24.7	100.0	84
Living children													
None	58.9	58.9	11.4	0.4	30.6	15.5	0.5	0.5	0.1	0.0	41.1	100.0	821
1	64.0	64.0	16.0	1.0	34.8	8.7	0.3	3.0	0.1	0.1	36.0	100.0	829
2	71.5	71.5	12.6	1.4	38.3	5.3	0.4	12.6	1.0	0.0	28.5	100.0	710
3	71.6	71.6	12.2	1.1	32.5	3.3	0.0	20.9	1.6	0.0	28.4	100.0	542
4+	61.2	61.2	7.7	0.0	27.2	1.5	0.0	24.4	0.3	0.0	38.8	100.0	413
Total	65.3	65.2	12.5	0.8	33.2	7.9	0.3	10.0	0.5	0.0	34.7	100.0	3,315

D. Maternity Care

In the survey, women who had given birth in the five years preceding the survey were asked a number of questions about maternal and child health care. For the last live birth in that period, mothers were asked whether they had received tetanus toxoid injections and whether they had obtained antenatal care during the pregnancy. For each birth in the same period, mothers were also asked who assisted them with the delivery. Table 10 presents the results of key maternity care indicators.

Table 10 Maternity care indicators

Percentage of women who had a live birth in the five years preceding the survey who received specific maternal health services during pregnancy for the most recent birth, and among all live births in the five years before the survey, percentage delivered by a health professional and percentage delivered in a health facility, by background characteristics, South Africa, 2003

Background characteristic	Given at least one tetanus toxoid injection[1]	Antenatal care[1]		Number of women	Assistance at delivery[1]		Number of births
		From doctor	From nurse/ midwife		From doctor	From nurse/ midwife	
Maternal age at birth							
<20	61.4	19.3	70.5	323	21.6	71.6	364
20-34	54.4	30.8	62.1	1,218	27.2	66.7	1,388
35+	48.8	30.8	57.2	284	34.5	47.8	322
Residence							
Urban	49.0	35.0	56.1	1,247	34.1	60.6	1,412
Rural	67.3	15.3	77.5	578	12.9	73.2	662
Province							
Western Cape	14.4	56.6	33.1	274	40.3	53.0	317
Eastern Cape	67.7	12.1	83.3	207	19.9	65.1	242
Northern Cape	65.4	20.1	69.8	43	30.8	63.6	48
Free State	72.9	14.2	76.4	122	15.2	76.7	136
KwaZulu-Natal	71.0	53.8	35.8	125	58.7	33.0	137
North West	56.5	17.5	76.4	176	14.1	79.8	196
Gauteng	48.4	31.2	58.6	500	33.9	61.3	571
Mpumalanga	66.0	16.2	77.0	141	18.3	74.2	166
Limpopo	75.8	17.7	75.7	237	9.1	78.6	261
Education							
No education	64.9	7.9	70.6	77	19.4	59.3	89
Grades 1-5	57.7	11.5	78.6	110	11.9	65.1	140
Grades 6-7	58.7	19.9	70.0	195	24.6	62.7	212
Grades 8-11	52.7	25.9	65.5	848	21.6	71.6	969
Grade 12	54.7	40.1	54.7	441	36.9	59.7	496
Higher	54.5	46.1	47.2	153	52.9	44.2	168
Population group							
African	58.8	24.7	67.6	1,532	23.3	68.0	1,732
Coloured	29.6	43.5	43.7	202	38.5	55.6	235
White	40.4	62.6	24.3	64	67.5	30.8	75
Asian	46.5	69.0	28.6	26	72.1	26.9	32
Birth order							
1	57.2	26.3	64.9	736	27.7	66.5	837
2-3	53.1	31.5	61.4	754	28.4	65.1	845
4-5	54.4	31.5	58.4	251	28.6	60.5	291
6+	49.5	17.4	71.6	84	11.8	56.5	102
Total	54.8	28.8	62.9	1,825	27.4	64.6	2,074

Note: If the respondent mentioned more than one source of antenatal or delivery care, the most qualified person is considered in this table.

[1] Includes only the most recent birth in the 5-year period preceding the survey.

[2] Includes all births in the 5-year period preceding the survey.

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, a cause of infant deaths. Table 10 indicates that antenatal tetanus toxoid coverage is far from complete in South Africa. Only just over half of mothers (55 percent) were given a tetanus toxoid injection during the pregnancy for their most recent birth. Tetanus coverage tends to fall with age of the mother, presumably because older mothers have received injections during prior pregnancies and are more likely to have lifetime immunity. Similarly, mothers are less likely to receive tetanus injections for sixth and higher order births than for lower order births.

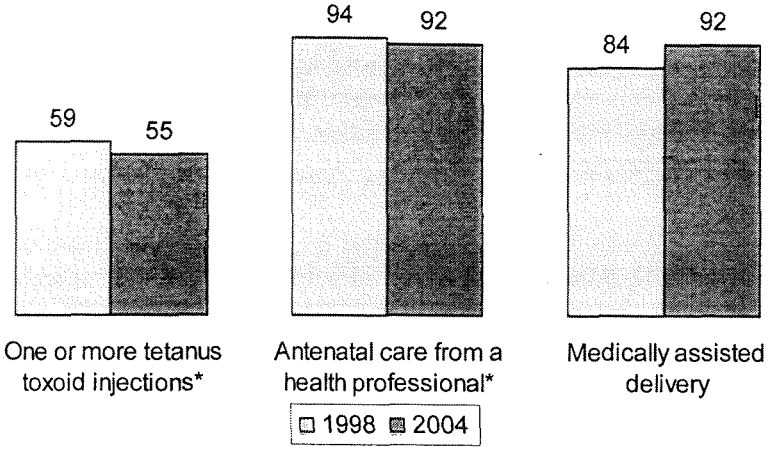
Rural mothers are more likely than urban mothers to have received a tetanus injection during pregnancy. Differences by province are marked, with an exceptionally low proportion in Western Cape (14 percent). Antenatal tetanus coverage is highest in Limpopo, Free State, and KwaZulu-Natal Provinces. The likelihood of receiving a tetanus toxoid injection during pregnancy is highest for mothers with no education and for African mothers.

Over nine in ten mothers (92 percent) reported seeing a health professional (doctor, nurse, or midwife) at least once for antenatal care for the most recent birth in the five-year period before the survey. Differentials in professional antenatal care coverage are generally minor, except that women with no education are less likely to receive any antenatal care. Differences by the type of provider, however, are strong. The proportion of women who receive antenatal care from a doctor is markedly higher among urban women, women in Western Cape and KwaZulu-Natal Provinces, women with more education, and White and Asian women.

Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause serious illness of the mother and/or the baby. Table 10 shows that 9 in 10 births in South Africa are delivered by a health professional. Differentials in delivery assistance generally follow those for antenatal care. Births in KwaZulu-Natal are by far the most likely to be assisted by doctors.

Analysis of trends in maternity care indicators is complicated by the fact that the 1998 SADHS asked questions on antenatal care and tetanus injections for all births in the five years prior to the survey, whereas the 2003 SADHS confined these questions to only the most recent birth. Figure 2 shows the trends in key maternity care indicators between the 1998 and 2003 SADHS surveys. Tetanus toxoid coverage has declined slightly from 59 to 55 percent of pregnant women. Antenatal care from health professionals remained more or less stable (94 percent in 1998 and 92 percent in 2003). The percentage of medically assisted deliveries has increased from 84 percent of births in 1998 to 92 percent of births in 2003.

Figure 2. Trends in maternity care indicators, South Africa



* For 2003-4, refers to most recent birth in previous five years; all other data refer to all births in previous five years

III. HIV AND AIDS INDICATORS

A. Knowledge of HIV and AIDS

The 2003 SADHS included a series of questions related to HIV and AIDS and sexually transmitted infections in both the Women's and Men's questionnaires. Both female and male respondents were asked if they have ever heard of AIDS, what a person could do to avoid getting AIDS, the number of sexual partners they had in the 12 months preceding the survey, and whether they had used condoms with any of these partners.

The survey found that 94 percent of women and 95 percent of men aged 15-49 have heard of AIDS (data not shown). The level of knowledge is so high that there are no significant differentials in knowledge by background characteristics. However, the level of awareness about HIV and AIDS among women has declined very slightly from 97 percent found in the 1998 SADHS.

Abstaining from sex, being faithful to one uninfected partner, and using condoms are important ways to avoid the spread of HIV and AIDS. To ascertain the depth of knowledge about modes of HIV and AIDS transmission, respondents were asked general questions as to whether there is anything a person can do to avoid getting AIDS or the virus that causes AIDS, and if so, what can be done. They were further prompted with specific questions about whether it is possible to reduce the chance of getting AIDS by having just one faithful sexual partner, using a condom at every sexual encounter and not having sex at all. Table 11 shows the percentage of women and men by their answers to these questions, according to background characteristics.

The results show that knowledge of HIV prevention methods is widespread, although there are differences between men and women. More than 4 in 5 men (86 percent) and 7 in 10 women (71 percent) indicate that the chances of getting the AIDS virus can be reduced by using condoms. Similarly, 82 percent of men and 75 percent of women know that limiting sex to one faithful and uninfected partner can reduce the risk of contracting the HIV virus. Knowledge of both these means of avoiding HIV transmission is also high, with 76 percent of men and 68 percent of women citing both as ways of reducing the risk of getting the AIDS virus. Finally, 83 percent of men and 70 percent of women know that abstinence can reduce the risk of getting HIV.

Knowledge of HIV prevention methods among women and men aged 15–19 is lower for all methods as compared to people aged 20 years and above. For all methods of reducing the risk of HIV infection, urban dwellers are more knowledgeable than their rural counterparts. The level of awareness by province shows that men in KwaZulu-Natal and women in Mpumalanga Province are better informed than those in other provinces. The least knowledgeable region is Eastern Cape Province for men and Limpopo Province for women.

Level of education is strongly related to respondents' knowledge of ways to avoid contracting HIV and AIDS. Men and women who have no education exhibit considerably lower levels of knowledge of HIV and AIDS prevention than those with some education. Asian and white respondents tend to be better informed about HIV prevention methods than African or coloured respondents.

Table 11 Knowledge of HIV and AIDS prevention methods

Percentage of men aged 15-59 and women aged 15-49 who, in response to a prompted question, say that people can reduce the risk of getting the AIDS virus by using condoms and by having sex with just one partner who is not infected and who has no other partners, and by abstaining, according to background characteristics, South Africa, 2003

	Men					Women				
Background characteristic	Using condoms	Limiting sex to one uninfected partner	Both using condoms and limiting to one partner	Abstaining from sex	Number of men	Using condoms	Limiting sex to one uninfected partner	Both using condoms and limiting to one partner	Abstaining from sex	Number of women
Age										
15-19	80.5	78.2	69.9	81.1	592	70.3	72.9	66.4	70.7	1,384
20-24	86.6	80.4	76.2	84.2	525	72.2	76.7	68.9	70.0	1,239
25-29	88.6	84.3	80.8	84.1	424	73.4	78.5	71.4	71.7	1,017
30-39	87.2	86.5	80.8	83.3	689	73.5	77.1	70.9	71.5	1,921
40-49	85.5	82.5	75.5	85.1	551	66.8	70.5	63.5	64.9	1,479
15-24	83.4	79.3	72.9	82.6	1,117	71.2	74.7	67.6	70.3	2,623
Residence										
Urban	86.1	83.4	77.7	83.5	2,259	74.8	78.9	71.8	73.1	4,871
Rural	80.6	77.3	70.2	80.3	859	63.2	66.3	60.1	62.1	2,170
Province										
Western Cape	86.4	82.7	75.4	82.5	373	73.7	76.5	71.1	71.1	899
Eastern Cape	72.4	64.2	58.5	71.2	294	67.3	71.8	62.0	59.7	750
Northern Cape	83.5	80.7	71.7	84.1	57	74.0	78.7	72.3	76.4	130
Free State	78.0	76.8	69.1	75.7	193	74.0	77.9	72.7	71.2	465
KwaZulu-Natal	90.0	89.8	83.5	94.6	796	67.1	72.4	65.8	68.2	1,311
North West	86.1	86.2	80.2	83.5	201	75.2	77.0	72.5	74.3	538
Gauteng	83.4	81.5	76.5	79.0	804	73.9	79.4	70.3	74.6	1,801
Mpumalanga	86.3	78.0	73.6	76.1	195	80.1	82.5	78.5	76.4	444
Limpopo	85.1	78.2	71.4	78.5	205	61.7	61.4	56.4	58.8	701
Education										
No education	65.3	66.6	56.0	64.9	136	43.8	47.0	40.3	43.4	295
Grades 1-5	74.2	68.5	59.7	70.9	217	52.8	55.9	51.4	48.9	428
Grades 6-7	77.0	75.2	68.2	78.0	303	62.7	65.4	59.1	61.2	713
Grades 8-11	85.2	80.8	75.1	81.1	1,364	71.5	74.9	68.0	70.2	3,269
Grade 12	88.4	87.8	81.7	89.1	814	78.6	83.4	76.0	75.9	1,716
Higher	96.0	92.7	90.0	93.6	284	85.0	90.4	82.9	86.9	620
Population group										
African	83.0	80.0	73.7	80.8	2,525	69.5	73.3	66.2	68.1	5,801
Coloured	85.3	82.3	73.8	85.7	269	70.4	73.8	68.7	68.4	682
White	96.3	93.0	90.6	94.6	251	90.4	94.5	89.1	90.1	415
Asian	98.0	99.1	97.5	96.1	68	88.0	93.7	85.4	83.9	141
Total	84.6	81.7	75.6	82.6	3,118	71.2	75.0	68.2	69.7	7,041

B. Number of Sexual Partners

Since an important way to reduce the transmission of the AIDS virus is to remain faithful to one partner, the 2003 SADHS asked questions about the number of partners respondents had in the 12 months preceding the survey. As shown in Table 12, less than 3 percent of women respondents reported having more than one sexual partner in the previous year, compared with 4 percent of men.

Men and women in their 20s are most likely to have multiple partners. Among men, the proportion reporting more than one partner increases with education level; among women, there is no consistent relationship.

Table 12 Number of sexual partners

Percentage of men aged 15-59 and women aged 15-49 who have had sexual intercourse with two or more partners in the 12 months preceding the survey, according to background characteristics, South Africa 2003

	Men		Women	
Background characteristic	2+ partners	Number of men	2+ partners	Number of women
Age				
15-19	2.8	592	2.9	1,384
20-24	9.8	525	3.7	1,239
25-29	8.7	424	4.0	1,017
30-34	5.7	347	2.3	925
35-39	1.1	341	1.3	997
40-44	1.0	326	1.3	817
45-49	0.0	226	0.6	662
50-54	3.1	185	na	na
55-59	0.0	152	na	na
Residence				
Urban	4.7	2,259	2.4	4,871
Rural	3.6	859	2.7	2,170
Education				
No education	0.4	136	1.0	295
Grades 1-5	3.1	217	2.0	428
Grades 6-7	1.3	303	1.4	713
Grades 8-11	3.8	1,364	2.9	3,269
Grade 12	6.4	814	2.8	1,716
Higher	7.9	284	1.6	620
Population group				
African	5.0	2,525	2.8	5,801
Coloured	1.8	269	1.5	682
White	2.3	251	1.1	415
Asian	3.2	68	0.5	141
Total	4.4	3,118	2.5	7,041

na = Not applicable

C. Use of Condoms

Since condom use is an important method of preventing the spread of HIV, women were asked about condom use. The data in Table 13 indicate that almost 40 percent of women who had

sexual intercourse in the 12 months prior to the survey, said they had ever used a condom. One-third of women said they had used a condom the last time they had sex, though the proportion varies by type of partner. Only 15 percent of women say they use condoms with their husbands or live-in partners, while 47 percent say they used a condom the last time they had sex with a non-cohabiting partner.

Table 13 Use of condoms

Among women 15-49 who had sexual intercourse in the 12 months preceding the survey, the percentage who ever used condoms, and percentage who used condoms during last sexual intercourse, according to type of partner and background characteristics, South Africa 2003

Background characteristic	Ever used condom	Number	Used condom during last sex: Used with spouse	Number	Used with non-spouse	Number	Used with any partner	Number
Age								
15-19	49.0	505	(11.1)	26	50.1	478	48.1	505
20-24	50.8	913	20.4	138	53.8	774	48.8	913
25-29	45.4	835	16.3	299	45.9	533	35.2	835
30-34	37.4	765	15.9	427	37.0	337	25.1	765
35-39	30.9	820	14.2	482	42.5	334	25.7	820
40-44	25.0	648	16.6	403	41.0	243	25.7	648
45-49	24.1	420	12.1	299	36.6	120	19.1	420
Residence								
Urban	38.6	3,439	14.5	1,469	49.4	1,959	34.3	3,439
Rural	38.5	1,467	17.6	603	39.9	860	30.7	1,467
Province								
Western Cape	24.9	605	10.8	314	38.6	286	23.8	605
Eastern Cape	33.9	485	15.0	187	41.5	297	31.2	485
Northern Cape	26.8	83	7.3	44	35.3	39	20.3	83
Free State	26.2	294	13.0	147	43.6	146	28.3	294
KwaZulu-Natal	55.7	896	28.9	336	57.6	557	46.6	896
North West	45.5	371	13.2	125	43.4	243	33.1	371
Gauteng	35.3	1,339	14.1	560	50.8	777	35.3	1,339
Mpumalanga	36.6	331	9.8	145	40.5	185	27.0	331
Limpopo	43.0	502	13.2	213	36.3	289	26.5	502
Education								
No education	12.1	222	10.9	131	17.8	90	13.7	222
Grades 1-5	20.6	301	8.3	165	27.1	135	16.7	301
Grades 6-7	20.5	490	10.1	248	30.3	238	19.9	490
Grades 8-11	36.0	2,129	14.1	809	44.1	1,314	32.6	2,129
Grade 12	50.3	1,271	21.5	480	56.8	785	43.2	1,271
Higher	60.1	493	20.5	238	62.8	255	42.4	493
Population group								
African	38.6	4,060	17.1	1,502	46.9	2,546	35.8	4,060
Coloured	25.7	431	8.4	241	36.7	188	20.7	431
White	53.9	318	15.7	243	(58.5)	75	25.8	318
Asian	43.2	95	4.7	85	(42.6)	10	8.7	95
Total	38.6	4,906	15.4	2,072	46.5	2,819	33.3	4,906

Note: Figures in parentheses are based on 25-49 unweighted cases.

Younger women, those in KwaZulu-Natal, and especially, those with more education are also more likely than other women to have used condoms.

IV. CHILD HEALTH

A. Treatment of Childhood Diarrhoea

Dehydration caused by severe diarrhoea can cause death. Prompt medical attention when a child has symptoms of diarrhoea is, therefore, crucial in reducing child deaths. To obtain information on how childhood illnesses are treated, the mothers of each child under five years of age were asked whether the child had experienced diarrhoea in the two weeks before the survey. Data for children under five who were not living with their biological mothers were obtained from the child's guardian using the Additional Child Questionnaire.

The results show that only 8 percent of children under age five years are reported to have had diarrhoea in the two weeks before the survey (Table 14). Almost two-thirds of these children were treated with some sort of oral rehydration therapy (ORT), with about 40 percent receiving oral rehydration salt solution (ORS) and about 40 percent receiving a home solution. Differences in treatment are difficult to analyse, given the small numbers of children with diarrhoea across the various categories.

Table 14 Prevalence of diarrhoea and use of oral rehydration therapy

Among children under five years of age, the percentage reported by the mother/guardian to have had diarrhoea in the two weeks preceding the survey, and of those with diarrhoea, percentage who were given oral rehydration salts (ORS) or a home solution, or either (ORT), by background characteristics, South Africa 2003

Background characteristic	Had diarrhoea in last 2 weeks	Diarrhoea treatment			Number of children under 5
		ORS packets	Home solution	Either ORT	
Age of child					
< 6 months	6.4	*	*	*	194
6-11 months	17.1	(30.9)	(45.5)	(59.9)	239
12-23 months	12.0	43.3	50.7	69.9	441
24-35 months	5.9	(39.6)	(34.6)	(62.9)	463
36-47 months	6.3	(33.5)	(39.7)	(60.2)	473
48-59 months	3.8	*	*	*	499
Sex of child					
Male	8.6	42.6	40.4	65.9	1,149
Female	7.1	35.5	38.8	60.2	1,160
Residence					
Urban	7.4	42.9	40.7	62.2	1,541
Rural	8.8	33.4	38.0	65.0	767
Province					
Western Cape	13.2	(39.4)	(42.8)	(54.5)	331
Eastern Cape	7.9	*	*	*	276
Northern Cape	15.7	40.9	44.8	76.9	55
Free State	14.5	(54.6)	(49.2)	(75.4)	158
KwaZulu-Natal	0.9	*	*	*	168
North West	6.8	*	*	*	235
Gauteng	4.0	*	*	*	584
Mpumalanga	6.5	*	*	*	193
Limpopo	10.1	(23.9)	(37.3)	(57.9)	307
Education					
No education	12.2	*	*	*	120
Grades 1-5	5.1	*	*	*	149
Grades 6-7	11.4	(45.4)	(66.2)	(90.9)	246
Grades 8-11	7.6	39.9	34.6	59.0	1,098
Grade 12	6.9	(40.2)	(36.1)	(62.5)	517
Higher	6.8	*	*	*	179
Population group					
African	7.6	42.8	41.0	67.0	1,950
Coloured	11.2	(25.2)	(27.8)	(39.7)	246
White	4.4	*	*	*	79
Asian	5.5	*	*	*	33
Total	7.9	39.4	39.7	63.3	2,309

B. Breastfeeding and Supplementation

Breastfeeding practices and introduction of supplemental foods are important determinants of the nutritional status of children, particularly those under the age of two years. With improved nutritional status, the risk of mortality among children under five years can be reduced and their psycho-motor development enhanced. Breast milk is uncontaminated

and contains all the nutrients needed by children in the first four to six months of life. Supplementing breast milk before four months of age is unnecessary and discouraged because of the likelihood of contamination, which may result in diarrhoeal diseases.

Table 15 Breastfeeding status by age

Percent distribution of youngest children under 12 months living with the mother by breastfeeding status and percentage of children under 12 months using a bottle with a nipple, according to age in months, South Africa, 2003

Age in months	Not breastfed	Exclusively breastfed	Breastfeeding and consuming: Plain water only	Other liquids	Solid or mushy food	Total	Percent using a bottle with a nipple	Number of children
<4	20.1	11.9	18.6	43.4	5.9	100.0	37.3	125
4-6	36.0	1.5	15.7	20.3	26.6	100.0	26.0	102
7-9	30.4	0.0	2.1	21.7	45.8	100.0	34.1	113
10-12	41.1	2.7	6.6	8.9	40.7	100.0	14.4	107
Total	31.3	4.3	10.9	24.4	29.1	100.0	28.5	447

Note: Breastfeeding status refers to a "24-hour" period (yesterday and last night). Children classified as breastfeeding and consuming plain water only consume no supplements. The categories of not breastfeeding, exclusively breastfed, breastfeeding and consuming plain water, other liquids, and solid or mushy food are hierarchical and mutually exclusive, and their percentages add to 100 percent. Thus children who receive breast milk and other liquids and who do not receive complementary foods are classified in the other liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well.

The results in Table 15 indicate that supplementation of breast milk starts early in South Africa. Exclusive breastfeeding (breast milk only) is not common as only 12 percent of children under four months of age are exclusively breastfed. Most of the supplements given are plain water or other liquids; only 6 percent of babies under four months and 27 percent of those aged 4-6 months of age are given mushy or semi-solid food. By age 7-9 months, almost half of children are given complementary foods, as is recommended.

Bottle feeding of infants is widespread. Nearly 40 percent of babies under four months of age are being fed using a bottle with a teat. This proportion declines among older children. These rates are lower than those reported in the 1998 SADHS.

C. Vitamin A Supplementation

Vitamin A is an essential micronutrient for the immune system and plays an important role in maintaining the epithelial tissue in the body. High levels of vitamin A deficiency can cause eye damage leading to blindness and can increase the severity of infections such as measles and diarrhoeal diseases in children. Ensuring that children between six months and 59 months receive enough vitamin A is a widely accepted child survival intervention.

As shown in Table 16, almost four in ten (39 percent) children aged 6 months to five years of age are reported to have received a vitamin A supplement in the six months preceding the survey. Variation in this figure by background characteristics is surprisingly minimal. Age of the child appears to have no clear pattern and supplementation coverage is the same for boys and girls. Rural children are, however, more likely to have received a supplement than urban children (46 percent vs. 36 percent).

Children in Eastern Cape (57 percent) and Northern Cape (49 percent) Provinces are most likely to have received a supplement, while those in Western Cape and North West Provinces (30 percent each) are the least likely. Supplementation levels by education of the mother do not follow a clear trend and they are only higher among children whose mothers have higher education. Similarly, age of the mother at birth appears to have no relationship with the likelihood that the child will receive vitamin A supplements.

Table 16 Vitamin A supplementation

Among children age 6-59 months of age, the percentage reported by the mother/ guardian to have had received vitamin A supplements in the 6 months preceding the survey, by background characteristics, South Africa 2003

Background characteristic	Received vitamin A supple-ment	Number of children
Age of child		
6-9 months	36.5	149
10-11 months	33.9	76
12-23 months	46.1	400
24-35 months	38.8	387
36-47 months	37.5	386
48-59 months	36.0	392
Sex of child		
Male	39.6	887
Female	38.7	903
Residence		
Urban	36.2	1,227
Rural	45.5	563
Province		
Western Cape	29.5	284
Eastern Cape	57.3	199
Northern Cape	49.3	43
Free State	46.1	115
KwaZulu-Natal	42.3	124
North West	30.2	164
Gauteng	32.2	490
Mpumalanga	46.7	153
Limpopo	44.6	219
Education		
No education	38.2	77
Grades 1-5	40.0	118
Grades 6-7	30.7	183
Grades 8-11	40.8	823
Grade 12	37.3	438
Higher	45.6	151
Mother's age at birth		
< 20	37.8	319
20-24	43.2	445
25-29	37.0	452
30-34	36.9	294
35-49	40.0	280
Total	39.1	1,790

D. Infant and Child Mortality

Childhood mortality rates are basic indicators of a country's socio-economic level and quality of life. Table 17 presents childhood mortality rates from the 2003 SADHS. Age-specific mortality rates are defined as follows:

Neonatal mortality: the probability of dying within the first month of life;

Postneonatal mortality: the difference between infant and neonatal mortality;

Infant mortality: the probability of dying before the first birthday;

Child mortality: the probability of dying between the first and fifth birthday;

Under-five mortality: the probability of dying before the fifth birthday.

All rates are expressed per 1,000 live births, except for child mortality, which is expressed per 1,000 children surviving to 12 months of age.

The level of under-five mortality was 58 deaths per 1,000 births during the five-year period before the survey, implying that 1 in every 17 children born in South Africa during the period died before reaching their fifth birthday. The infant mortality rate recorded in the survey was 43 deaths per 1,000 live births for the five-year period prior to the survey. These levels are lower than those estimated from other sources (e.g., Bradshaw and Nannan, 2004, estimate the infant mortality rate at 59 and the under-five mortality rate at 100 in 2002).

Table 17 Early childhood mortality rates by background characteristics

Neonatal, postneonatal, infant, child, and under-five mortality rates for the 10-year period preceding the survey, by background characteristic, South Africa, 2003

Background characteristic	Neonatal mortality (NN)	Postneonatal mortality (PNN)[1]	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-five mortality ($_5q_0$)
Residence					
Urban	20.4	21.2	41.6	10.3	51.4
Rural	18.6	25.5	44.1	12.3	55.9
Province					
Western Cape	5.4	38.1	43.5	13.6	56.5
Eastern Cape	(11.9)	(56.4)	(68.3)	(11.6)	(79.1)
Northern Cape	18.4	10.3	28.7	10.6	39.1
Free State	33.0	15.1	48.1	21.1	68.2
KwaZulu-Natal	22.6	7.8	30.4	3.0	33.2
North West	26.9	35.0	61.9	15.3	76.3
Gauteng	24.2	9.3	33.5	9.4	42.6
Mpumalanga	21.5	18.9	40.5	12.3	52.2
Limpopo	19.9	14.2	34.1	10.1	43.9
Education					
No education	(26.2)	(27.6)	(53.8)	(3.7)	(57.3)
Grades 1-5	18.9	65.8	84.8	16.9	100.3
Grades 6-7	13.5	23.9	37.4	10.9	47.8
Grades 8-11	26.3	20.2	46.5	12.8	58.7
Grade 12	15.6	15.7	31.3	10.7	41.7
Higher	(1.4)	(2.9)	(4.3)	(1.7)	(6.0)
Population group					
African	22.5	22.5	45.0	9.8	54.4
Coloured	6.0	35.1	41.1	18.2	58.6
White	*	*	*	*	*
Asian	(21.1)	(3.7)	(24.8)	(9.9)	(34.4)
Sex of child					
Male	26.0	21.4	47.4	13.2	60.0
Female	13.6	23.8	37.4	8.7	45.7
Total[2]	15.0	27.5	42.5	15.8	57.6

Note: Figures in parentheses are based on 250-499 cases, while an asterisk denotes a figure based on fewer than 250 cases that has been suppressed.

[1] Computed as the difference between the infant and neonatal mortality rates

[2] Total rates are for the five years before the survey

Under-five mortality is only slightly higher in rural areas than in urban areas. It is highest in Eastern Cape and North West Provinces and lowest in KwaZulu-Natal Province. Mortality is highest among the African and Coloured population groups. As expected, under-five mortality rates are higher for boys than girls.

Comparison of mortality rates recorded in the 2003 SADHS with those from the 1998 SADHS survey shows no significant change at the national level. Under-five mortality has remained stable (59 per 1,000 from the 1998 SADHS, compared with 58 for the 2003 SADHS), as has infant mortality (45 vs. 43). There have been large changes by background characteristics; however, due to the high level of sampling errors associated with childhood mortality rates, the data should be viewed with caution.

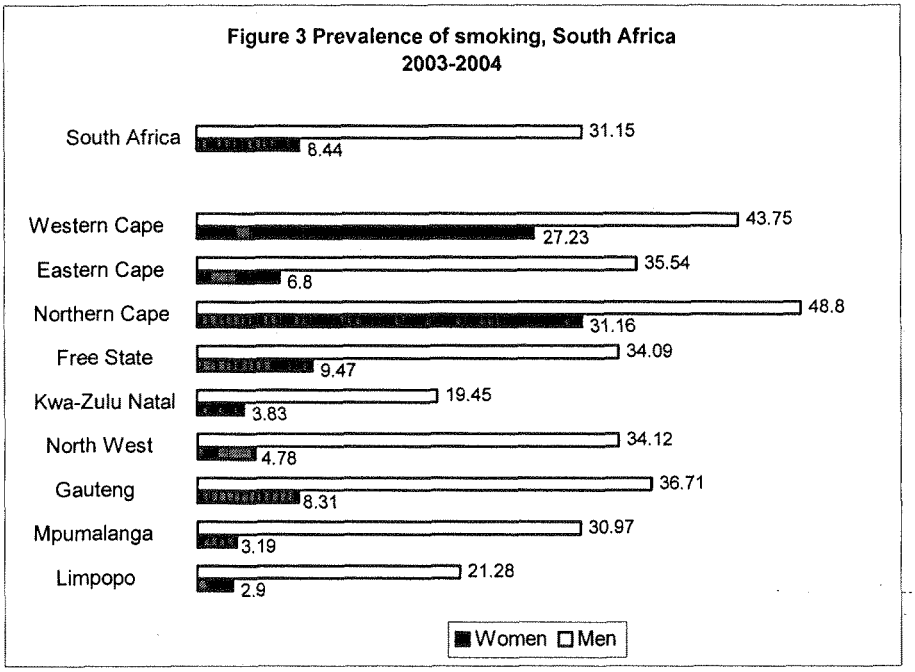
V. ADULT HEALTH

In the adult health questionnaire, data were collected from men and women aged 15 and over on self-reported lifestyle habits that influence health and on commonly occurring chronic adult diseases. The blood pressure, height, weight, hip, and waist circumferences were measured, as was peak expiratory flow. Respondents were also asked whether they had any of a number of specific chronic health conditions.

A. Smoking

Figure 3 shows that approximately one-third (31 percent) of men aged 15 and above smoke daily, compared to only 8 percent of women. This strong male-female ratio holds for each province. Among both sexes, smoking is more prevalent in Northern Cape and Western Cape and is lowest among those in KwaZulu-Natal, Limpopo, and Mpumalanga Provinces.

Figure 3 Prevalence of smoking, South Africa 2003-2004



The proportion of men aged 15 and over who reported smoking daily has declined from 42 percent in 1998 to 31 percent in 2003 and has declined from 11 percent in 1998 to 8 percent in 2003 among women.

B. Self-reported Chronic Conditions

Data on self-reported chronic conditions for men and women are shown in Tables 18.1 and 18.2, respectively. Men and women most frequently report suffering from high blood pressure and arthritis. Women are more likely than men to report having almost all of the chronic conditions asked about; however, men are more likely than women to report having tuberculosis.

Comparison with similar data from the 1998 SADHS shows very little change in the overall level of reporting of these conditions.

Table 18.1 Self-reported chronic conditions: men

Percent of male respondents age 15 and above who were told by a doctor, nurse, or health worker at a clinic or hospital that they have chronic health conditions, according to background characteristics, South Africa 2003

Background characteristic	High blood pres-sure	Heart attack or angina	Stroke	High blood choles-terol	Dia-betes	Emphy-sema	As-thma	Arth-ritis	Osteo-porosis	Epi-lepsy	Tuber-culosis	Cancer	Number
Age													
15-24	1.7	1.2	0.1	0.2	1.3	0.8	1.9	1.5	0.4	0.5	1.8	0.5	1,130
25-34	2.9	2.0	0.7	0.6	0.4	1.1	2.7	3.2	0.7	0.8	3.4	0.1	727
35-44	10.6	2.4	0.5	3.5	1.8	1.7	2.4	3.8	0.5	1.6	3.0	0.2	601
45-54	18.2	4.4	1.0	6.3	5.9	4.3	4.1	10.6	1.4	1.1	6.1	1.1	433
55-64	17.9	5.1	4.8	1.7	7.0	5.2	5.5	13.1	1.9	0.9	3.9	1.0	295
65+	26.2	7.0	1.5	2.9	5.2	2.3	5.4	12.7	4.0	2.9	6.7	1.8	254
Residence													
Urban	10.0	3.2	0.7	2.6	2.8	2.2	2.9	5.7	0.8	1.1	3.7	0.7	2,408
Rural	6.0	1.7	1.4	0.3	1.9	1.3	3.2	4.2	1.6	0.9	2.8	0.4	1,033
Province													
Western Cape	14.8	5.7	1.0	5.4	3.7	3.4	5.7	8.5	0.4	0.0	7.8	1.4	344
Eastern Cape	9.2	3.5	0.9	2.4	2.7	6.4	3.9	5.6	0.6	2.6	8.3	0.6	354
Northern Cape	14.1	2.8	1.4	1.4	3.0	2.7	1.9	6.3	2.4	2.9	2.5	0.3	59
Free State	13.3	3.7	0.8	1.2	1.8	1.9	2.0	4.1	2.2	2.5	4.5	0.3	222
KwaZulu-Natal	6.2	1.7	0.5	1.0	2.5	0.5	1.2	3.3	0.4	0.3	1.0	0.3	850
North West	9.2	3.7	2.1	0.4	1.5	1.4	3.6	6.0	5.8	1.7	5.0	0.4	238
Gauteng	9.2	2.4	0.6	2.3	2.6	1.8	3.9	6.4	0.0	0.6	2.7	0.9	914
Mpumalanga	3.1	2.7	1.8	1.7	2.5	1.0	2.6	3.0	1.4	1.4	0.0	0.0	200
Limpopo	6.6	0.6	1.6	1.2	2.4	0.6	1.6	4.2	1.7	1.6	2.1	0.3	259
Education													
No education	15.1	5.6	2.6	0.6	3.3	2.3	4.0	9.8	3.4	2.7	7.1	0.4	288
Grades 1-5	10.6	5.9	1.9	3.2	3.9	3.9	3.8	7.3	1.7	1.5	7.6	0.6	328
Grades 6-7	10.8	3.7	2.5	1.4	4.0	3.1	3.4	6.5	1.5	1.0	3.6	0.2	375
Grades 8-11	7.0	2.4	0.4	2.1	2.4	1.7	3.8	4.6	0.8	1.1	2.9	0.6	1,370
Grade 12	6.0	1.2	0.2	1.7	1.6	1.6	1.0	2.3	0.1	0.1	1.5	0.5	730
Higher	12.8	1.0	0.2	2.4	1.8	0.3	2.0	6.9	0.5	1.0	2.3	1.6	351
Population group													
African	6.9	2.8	0.9	1.0	1.8	1.7	2.5	4.3	1.1	1.0	3.6	0.3	2,832
Coloured	15.3	2.1	1.5	3.8	3.1	3.2	3.9	8.1	0.8	0.6	4.4	0.8	259
White	23.3	0.9	0.3	9.8	8.6	3.7	8.0	12.8	0.1	2.7	1.2	4.6	234
Asian	14.1	8.1	0.8	8.4	11.4	2.7	4.1	8.4	0.4	0.3	0.7	0.0	76
Total	8.8	2.7	0.9	2.0	2.6	2.0	3.0	5.2	1.0	1.1	3.4	0.6	3,441

Table 18.2 Self-reported chronic conditions: females

Percent of female respondents age 15 and above who were told by a doctor, nurse, or health worker at a clinic or hospital that they have chronic health conditions, according to background characteristics, South Africa 2003

Background characteristic	High blood pressure	Heart attack or angina	Stroke	High blood cholesterol	Diabetes	Emphysema	Asthma	Arthritis	Osteoporosis	Epilepsy	Tuberculosis	Cancer	Number
Age													
15-24	3.1	0.9	0.0	0.8	0.4	1.0	2.7	1.3	0.1	0.8	1.9	0.4	1,248
25-34	8.8	2.5	0.1	0.9	1.1	1.6	3.5	3.3	1.1	0.6	1.2	0.9	998
35-44	19.2	2.9	1.0	2.3	2.9	2.2	5.1	7.4	1.4	0.9	2.6	0.6	860
45-54	33.5	7.8	1.6	3.7	6.7	4.1	5.8	16.6	4.8	2.4	3.2	1.1	694
55-64	40.1	8.2	3.6	4.8	12.5	4.8	6.7	20.8	3.7	1.6	1.9	2.0	464
65+	41.4	7.6	2.3	3.3	8.6	5.4	5.5	14.6	8.4	2.5	3.5	0.9	410
Residence													
Urban	20.7	3.6	1.0	2.5	4.3	2.9	4.6	9.5	2.4	1.3	2.2	0.9	3,128
Rural	15.1	4.6	1.0	1.4	3.0	1.8	4.0	5.5	2.3	1.2	2.1	0.7	1,546
Province													
Western Cape	23.2	2.7	1.3	3.2	6.6	5.7	8.8	10.5	1.8	1.0	4.0	1.3	582
Eastern Cape	22.1	3.7	0.4	2.1	3.8	2.4	8.1	13.2	1.2	0.8	6.2	0.4	540
Northern Cape	25.2	3.3	1.6	2.4	3.0	3.7	4.4	10.3	2.7	1.9	2.3	0.5	91
Free State	26.5	8.9	0.8	1.7	4.0	1.7	2.7	5.9	0.6	3.9	3.1	0.9	312
KwaZulu-Natal	11.2	2.2	0.2	1.3	4.0	0.8	2.3	6.1	0.7	1.0	0.4	0.5	956
North West	20.9	7.1	2.0	2.1	1.8	2.9	3.6	8.8	10.1	2.2	3.1	0.3	355
Gauteng	21.2	3.1	1.6	2.6	3.5	2.2	3.7	8.8	2.1	0.7	1.0	1.2	1,074
Mpumalanga	14.9	4.5	1.1	1.3	2.1	2.1	4.2	4.0	2.3	1.3	1.6	0.5	286
Limpopo	14.5	5.5	1.0	2.3	3.5	3.5	2.4	5.7	3.5	1.3	0.9	1.2	477
Education													
No education	32.7	8.1	1.4	2.5	6.5	3.4	5.8	13.1	4.5	1.8	4.2	0.8	554
Grades 1-5	32.0	6.5	1.4	1.4	7.3	2.3	6.3	15.3	1.8	2.6	4.6	1.5	438
Grades 6-7	25.9	5.9	2.2	2.9	4.1	2.9	6.3	8.7	2.8	1.6	2.1	0.5	493
Grades 8-11	15.9	3.3	0.6	2.4	3.3	2.4	3.8	6.8	2.6	1.0	1.8	1.0	1,879
Grade 12	8.0	1.4	0.4	1.5	1.6	2.2	3.9	5.4	0.9	0.6	1.3	0.6	937
Higher	15.5	1.9	2.1	1.6	4.1	2.6	1.5	6.1	1.6	1.2	1.0	0.1	374
Population group													
African	18.9	4.1	0.9	1.5	3.6	1.9	3.8	7.5	2.4	1.3	2.1	0.7	3,787
Coloured	24.0	2.8	1.0	2.9	5.5	5.1	8.5	10.7	0.8	0.8	5.1	1.4	446
White	9.9	3.2	2.4	7.9	1.1	6.6	6.9	10.9	4.6	0.7	0.0	2.5	283
Asian	20.3	6.3	0.8	6.9	12.5	3.3	5.1	15.7	0.9	0.5	0.0	0.6	100
Total	18.8	3.9	1.0	2.1	3.9	2.6	4.4	8.2	2.4	1.2	2.2	0.8	4,674

C. Body Mass Index

The body mass index (BMI or Quetelet index) is used to measure thinness or obesity. It is defined as weight in kilograms divided by height in metres squared (kg/m^2). A cut-off point of 18.5 is used to define thinness or acute undernutrition. A BMI of 25 or above usually indicates overweight, while a BMI of 30 or above usually indicates obesity.

Tables 19.1 and 19.2 present data on BMI for men and women aged 15 and above, respectively. The data show that 9 percent of adult men and 23 percent of adult women in South Africa are obese, while 21 percent of men and 29 percent of women are overweight but not obese. Obesity is more prevalent among older men and women, as well as those in urban rather than rural areas. Among men, obesity is more common in Western Cape, Gauteng, and KwaZulu-Natal Provinces, while among women, it is more common in Eastern Cape, Gauteng, and Western Cape Provinces. (The relatively low proportion of men and women in KwaZulu-Natal who are underweight needs further checking). Obesity does not seem to be highly related to education, although it is higher for the most educated men.

Table 19.1 Body mass index: men

Percent distribution of men age 15 and above by body mass index (BMI) categories, according to background characteristics, South Africa 2003

Background characteristic	Underweight (<18.5)	Normal (18.5-24.9)	Overweight (25.0-29.9)	Obese (30.0+)	Total	Number
Age						
15-24	19.9	68.3	10.0	1.8	100.0	1100
25-34	8.4	61.3	20.7	9.6	100.0	708
35-44	8.3	52.6	26.2	12.9	100.0	574
45-54	8.5	45.3	32.5	13.8	100.0	419
55-64	9.7	48.1	28.9	13.3	100.0	285
65+	9.5	44.5	32.1	13.8	100.0	221
Residence						
Urban	11.7	57.7	20.2	10.4	100.0	2214
Rural	13.8	58.1	22.8	5.3	100.0	1093
Province						
Western Cape	9.3	52.2	23.6	15.0	100.0	274
Eastern Cape	10.8	63.8	16.4	9.1	100.0	355
Northern Cape	25.7	55.1	13.8	5.5	100.0	62
Free State	18.0	60.0	13.4	8.6	100.0	237
KwaZulu-Natal	3.9	55.3	31.8	8.9	100.0	798
North West	19.7	57.9	17.6	4.8	100.0	252
Gauteng	14.3	55.9	20.1	9.7	100.0	847
Mpumalanga	16.1	61.6	16.3	6.0	100.0	220
Limpopo	19.5	64.9	11.0	4.6	100.0	262
Education						
No education	13.9	50.7	24.4	11.0	100.0	281
Grades 1-5	14.5	50.5	24.8	10.2	100.0	331
Grades 6-7	15.8	58.8	16.6	8.8	100.0	374
Grades 8-11	14.0	60.3	19.5	6.3	100.0	1304
Grade 12	9.5	61.1	19.7	9.7	100.0	685
Higher	5.4	52.3	29.9	12.5	100.0	303
Population group						
African	13.1	59.4	20.4	7.1	100.0	2790
Coloured	11.6	51.9	21.0	15.6	100.0	235
White	4.9	47.6	25.0	22.6	100.0	200
Asian	9.8	45.5	34.1	10.7	100.0	69
Total	12.4	57.8	21.1	8.7	100.0	3,307

Among men, obesity is highest among the White population group and lowest among African men. Among women, African, Coloured and Asian women are almost equally likely to be obese, while the proportion of White women who are obese is relatively lower.

A comparison of data from the 2003 and 1998 SADHS surveys shows minimal changes in the overall categories among men, although there has been a slight decline in the proportion of men who are obese. Among women, there has been a decline in the proportion obese, from 30 percent in 1998 to 27 percent in 2003. The decline has been particularly steep among White and African women, but is also apparent among Coloured women. The proportion that is obese among Asian women has remained stable since 1998.

Table 19.2 Body mass index: women

Percent distribution of women age 15 and above by body mass index (BMI) categories, according to background characteristics, South Africa 2003

Background characteristic	Underweight (<18.5)	Normal (18.5-24.9)	Overweight (25.0-29.9)	Obese (30.0+)	Total	Number
Age						
15-24	10.6	58.2	20.0	11.2	100.0	1,201
25-34	5.2	39.8	29.3	25.8	100.0	938
35-44	4.1	30.8	29.8	35.4	100.0	846
45-54	3.0	28.3	27.9	40.9	100.0	687
55-64	5.0	26.2	34.8	34.0	100.0	447
65+	5.0	29.2	33.3	32.6	100.0	360
Residence						
Urban	5.6	36.3	27.9	31.0	100.0	2,878
Rural	6.8	43.9	28.4	20.9	100.0	1,601
Province						
Western Cape	8.9	34.4	26.1	30.6	100.0	457
Eastern Cape	3.2	36.4	28.0	32.4	100.0	526
Northern Cape	12.2	41.9	21.6	24.3	100.0	96
Free State	7.7	42.8	23.3	26.2	100.0	326
KwaZulu-Natal	3.0	39.5	32.9	24.5	100.0	898
North West	8.0	42.5	25.1	24.3	100.0	374
Gauteng	5.7	36.1	28.2	30.1	100.0	1,005
Mpumalanga	6.0	39.9	25.9	28.2	100.0	313
Limpopo	9.1	45.0	24.1	21.8	100.0	485
Education						
No education	6.6	36.4	30.4	26.5	100.0	547
Grades 1-5	6.9	31.2	32.3	29.7	100.0	432
Grades 6-7	6.4	33.1	25.4	35.1	100.0	484
Grades 8-11	6.8	41.7	25.2	26.4	100.0	1,783
Grade 12	4.7	43.5	27.3	24.5	100.0	886
Higher	3.5	38.9	33.8	24.0	100.0	322
Population group						
African	5.6	38.2	27.8	28.4	100.0	3,759
Coloured	11.6	35.8	26.0	26.6	100.0	387
White	4.1	59	23.5	13.5	100.0	233
Asian	5.5	36.8	33.8	23.9	100.0	93
Total	6.0	41.3	29.0	23.3	100.0	4,480

D. Work-related Illness or Injury

The 2003 SADHS asked adults who had worked for pay in the 12 months preceding the survey whether they had any injury or health problems caused by their work in the previous year. The data in Table 20 show that 8 percent of working men and 4 percent of working women report a work-related illness or injury. The prevalence of such illnesses/injuries is higher among men in Western Cape and Limpopo Provinces and among women in Eastern Cape Province. Among both men and women, work-related injury and illness generally decline as education increases. White men are the least likely to report a work-related illness or injury in the previous 12 months, while White women are the most likely.

Comparison with data from the 1998 SADHS shows little change in the prevalence of work-related illness and injury.

Table 20 Prevalence of work-related illness and injury

Among working men and women age 15 and above, the prevalence of injury or work-related health problems in the 12 months preceding the survey, according to background characteristics, South Africa 2003

	Men		Women		Total	
Background characteristic	Percent injured	Number of working men	Percent injured	Number of working women	Percent injured	Number of working adults
Age						
15-24	8.9	215	2.9	164	6.3	379
25-34	8.8	410	4.9	340	7.0	750
35-44	8.0	398	3.8	377	6.0	776
45-54	6.7	232	5.0	219	5.9	451
55-64	5.2	102	5.7	73	5.4	175
65+	(3.8)	26	*	19	(2.2)	44
Residence						
Urban	8.0	1,094	4.7	952	6.5	2,046
Rural	7.4	289	2.5	240	5.2	529
Region						
Western Cape	13.6	211	4.7	270	8.6	482
Eastern Cape	8.2	103	6.5	79	7.5	182
Northern Cape	6.7	28	2.3	24	4.7	52
Free State	8.4	87	5.6	68	7.2	154
KwaZulu-Natal	3.2	286	2.0	211	2.7	497
North West	8.8	92	4.0	82	6.5	174
Gauteng	7.7	424	4.7	321	6.4	745
Mpumalanga	5.8	66	5.2	65	5.5	131
Limpopo	10.1	86	4.1	71	7.4	157
Education						
No education	10.5	86	7.3	78	9.0	164
Grades 1-5	10.5	128	4.8	76	8.4	204
Grades 6-7	6.2	136	1.8	112	4.2	248
Grades 8-11	9.6	443	6.0	372	8.0	815
Grade 12	7.6	370	3.3	343	5.5	713
Higher	3.3	220	2.8	211	3.1	431
Population group						
African	8.8	1,005	3.9	784	6.7	1,788
Coloured	9.8	164	2.7	211	5.8	375
White	0.9	157	8.7	147	4.6	304
Asian	5.9	51	5.2	35	5.6	86
Total	7.9	1,383	4.3	1,192	6.2	2,575

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

E. Asthma and Chronic Bronchitis

Men and women interviewed with the Adult Health Questionnaire were asked questions about symptoms related to asthma and bronchitis. As Table 21 shows, 8 percent of men and 9 percent of women had symptoms associated with asthma (see note below table). Only 2 percent of men and women had symptoms related to chronic bronchitis.

Both conditions become more prevalent with age. Both are also more common among men and women in Western Cape and Eastern Cape Provinces and for bronchitis, among women in North West and Limpopo Provinces. The strong negative association between these conditions and education may be due to the fact that older respondents tend to have less education than younger ones; consequently, the pattern may be due at least in part to age instead of education.

Table 21 Prevalence of symptomatic asthma and chronic bronchitis

Percentage of men and women age 15 and over who report symptoms of asthma and chronic bronchitis, according to background characteristics, South Africa 2003

Background characteristic	Men			Women		
	Asthma	Bronchitis	Number of men	Asthma	Bronchitis	Number of women
Age						
15-24	5.7	0.7	1,130	6.5	1.3	1,248
25-34	7.7	1.8	727	7.6	1.1	998
35-44	6.6	2.3	601	8.2	2.4	860
45-54	10.2	4.5	433	11.1	2.6	694
55-64	12.6	4.1	295	11.4	2.7	464
65+	11.2	4.8	254	9.4	2.5	410
Residence						
Urban	8.4	2.4	2,408	8.8	1.6	3,128
Rural	6.5	1.9	1,033	7.7	2.6	1,546
Province						
Western Cape	12.6	5.3	344	12.3	2.9	583
Eastern Cape	14.2	5.5	354	13.4	3.9	540
Northern Cape	9.3	3.3	59	9.7	1.9	91
Free State	11.7	2.5	222	7.4	2.5	312
KwaZulu-Natal	1.3	0.1	850	4.2	0.0	956
North West	7.2	1.6	238	8.0	3.6	355
Gauteng	9.0	2.1	914	6.4	0.8	1,074
Mpumalanga	7.6	1.2	200	11.8	1.1	286
Limpopo	7.5	2.5	259	10.2	3.5	477
Education						
No education	17.5	5.0	288	13.1	3.6	554
Grades 1-5	13.8	5.9	328	11.3	3.6	438
Grades 6-7	10.2	2.1	375	10.1	3.4	493
Grades 8-11	8.0	2.5	1,370	8.1	1.8	1,879
Grade 12	2.1	0.0	730	4.9	0.2	937
Higher	3.0	0.6	351	6.9	0.6	374
Population group						
African	8.0	2.3	2,832	8.3	2.0	3,787
Coloured	9.7	4.1	259	10.0	2.5	446
White	4.5	1.5	234	6.4	0.5	283
Asian	7.3	0.4	76	15.4	0.3	100
Total	7.8	2.3	3,441	8.5	1.9	4,674

Note: Asthma is defined as having wheezing or tightness of the chest in the 12 months preceding the survey *and* sleep interrupted by wheezing or a tight chest. Bronchitis is defined as having a regular cough that is productive (i.e., bringing up phlegm) every day for at least three months a year for two years or more.

VI. SOCIAL DEVELOPMENT

A. Orphanhood

Information on the survival status of parents and living arrangements of children under the age of 15 years is useful from a social point of view. As can be seen in Table 22, only about three-quarters of children under 15 have both their natural parents still alive. Two percent have lost their mothers only, 11 percent have lost their fathers only, while two percent have lost both parents. Information is missing for 8 percent of children. Older children are more likely to have a deceased parent. Among children age 10-14, 4 percent have both parents deceased. The highest percentage of children who have lost only their father (14 percent) and the highest percentage of children of whom only mother died (3 percent) were also recorded in this age group.

Table 22 Orphanhood

Percent distribution of de jure children under age 15 by survival status of parents, according to background characteristics, South Africa, 2003

Background characteristic	Both parents dead	Mother only dead	Father only dead	Both parents alive	Information missing	Total
Age						
0-1	0.3	0.1	6.3	87.8	5.5	100.0
2-4	0.9	1.1	6.8	84.9	6.2	100.0
5-9	1.7	1.8	11.2	77.2	8.1	100.0
10-14	4.0	2.7	13.7	71.4	8.2	100.0
Sex						
Male	2.2	2.0	11.3	76.4	8.0	100.0
Female	2.6	1.8	10.9	77.4	7.3	100.0
Residence						
Urban	2.4	1.4	10.9	78.8	6.5	100.0
Rural	2.4	2.7	11.4	74.3	9.2	100.0
Province						
Western Cape	1.8	0.6	6.0	88.5	3.0	100.0
Eastern Cape	1.5	2.6	15.0	67.8	13.1	100.0
Northern Cape	1.8	3.9	9.6	82.1	2.6	100.0
Free State	2.6	2.6	10.3	69.7	14.9	100.0
KwaZulu-Natal	4.8	3.4	12.8	72.1	6.8	100.0
North West	1.8	1.1	9.4	80.8	7.0	100.0
Gauteng	2.7	1.2	12.4	79.5	4.2	100.0
Mpumalanga	1.7	2.4	9.7	81.5	4.7	100.0
Limpopo	1.1	1.1	9.9	76.7	11.2	100.0
Total	2.4	1.9	11.1	76.9	7.6	100.0

B. Children's Living Arrangements

Table 23 shows the living arrangements for children aged 0-14. More than half the children under the age of one year, stay with their mothers only and just more than one-third stay with both parents. Provincial differentials show that in KwaZulu-Natal one or both parents of 21 percent of the children were deceased.

Table 23 Children's living arrangements

Percentage of de jure children under age 15 who are orphans, and percent distribution by children's living arrangements, according to background characteristics, South Africa, 2003

Background characteristic	Orphans[1]	Children's living arrangements: Not living with either parent	Living only with mother	Living only with father	Living with both parents	Total	Number of children
Age							
0-1	6.8	6.7	58.8	0.5	34.1	100.0	917
2-4	9.3	18.6	43.6	1.8	36.0	100.0	1,419
5-9	15.6	24.9	38.2	2.8	34.1	100.0	3,134
10-14	21.2	31.0	32.5	3.0	33.5	100.0	3,985
Sex							
Male	16.4	24.9	38.2	3.0	34.0	100.0	4,710
Female	16.0	24.7	39.0	2.1	34.2	100.0	4,744
Residence							
Urban	15.3	19.2	37.6	2.0	41.1	100.0	5,580
Rural	17.4	32.8	40.0	3.2	24.0	100.0	3,876
Province							
Western Cape	8.6	11.5	29.5	1.1	57.9	100.0	1,024
Eastern Cape	20.4	35.1	41.3	3.2	20.5	100.0	1,306
Northern Cape	15.4	26.0	37.1	4.1	32.8	100.0	190
Free State	16.9	28.7	39.5	2.9	28.9	100.0	630
KwaZulu-Natal	21.2	28.4	30.3	5.2	36.0	100.0	1,585
North West	13.3	32.0	46.9	1.5	19.7	100.0	857
Gauteng	17.0	13.2	36.7	1.2	48.9	100.0	1,937
Mpumalanga	14.3	28.0	46.5	2.6	22.9	100.0	709
Limpopo	13.1	29.4	46.6	1.9	22.1	100.0	1,218
Total	16.2	24.8	38.6	2.5	34.1	100.0	9,456

[1] Mother, father, or both parents dead

C. Grants

In the household questionnaire, questions relating to social grants were included in order to establish to what extent grants are utilised in South Africa. Table 24 shows that overall, 16 percent of people in South Africa are reported to be receiving some sort of grant. Women are slightly more likely than men to be receiving a grant (18 percent vs. 14 percent). Children and the elderly are most likely to be grant recipients, as are those who live in rural areas and in Eastern Cape and Limpopo Provinces.

Table 25 gives a summary of the type of grants people receive. It is clear that the two types of grants that are most common are child support grants and old age pensions. These grants account for almost 40 percent of grant recipients each.

Table 24 Grants

Percentage of males and females who receive any type of grant, according to background characteristics, South Africa 2003

Background characteristic	Males		Females		Total	
	Percent	Number	Percent	Number	Percent	Number
Age						
0-4	39.5	1,158	43.2	1,168	41.4	2,326
5-9	30.2	1,594	30.5	1,556	30.4	3,151
10-14	2.6	1,951	2.7	2,022	2.7	3,975
15-19	1.4	1,491	1.1	1,591	1.2	3,083
20-24	1.3	1,288	2.6	1,419	1.9	2,708
25-29	3.4	1,017	2.8	1,143	3.1	2,161
30-34	3.5	899	3.0	1,061	3.2	1,960
35-39	3.1	867	3.7	1,148	3.5	2,016
40-44	5.3	774	6.3	917	5.8	1,691
45-49	4.9	643	7.6	784	6.4	1,426
50-54	10.7	476	14.2	848	12.9	1,324
55-59	14.1	399	22.7	578	19.2	977
60-64	33.5	397	64.7	556	51.7	953
65+	70.2	664	87.1	939	80.1	1,602
Residence						
Urban	11.8	8,933	15.3	10,129	13.7	19,064
Rural	18.2	4,691	21.4	5,617	19.9	10,311
Province						
Western Cape	10.8	1,547	13.1	1,778	12.0	3,326
Eastern Cape	20.6	1,556	25.2	1,971	23.2	3,527
Northern Cape	20.0	258	22.1	305	21.1	563
Free State	18.6	871	20.5	1,068	19.6	1,939
KwaZulu-Natal	9.5	2,857	13.8	2,929	11.7	5,786
North West	19.7	1,052	22.4	1,322	21.2	2,376
Gauteng	9.2	3,297	11.7	3,590	10.5	6,887
Mpumalanga	15.7	897	20.1	1,040	18.0	1,937
Limpopo	21.8	1,289	23.3	1,741	22.7	3,033
Total	14.0	13,624	17.5	15,746	15.9	29,375

Note: Those missing information as to grant status (<2 %) assumed not to have a grant. Table based on de facto population enumerated in the household questionnaire.

Table 25 Type of grants

Percent distribution of those receiving grants by type of grant received, South Africa 2003

Type	Males	Females	Total
Old age	29.5	46.7	39.7
Disability	14.4	10.0	11.8
War veteran	0.2	0.2	0.2
Care dependency	2.8	1.9	2.3
Foster child	2.6	2.4	2.5
Child support	46.8	34.7	39.7
Social relief of distress	2.7	3.5	3.2
Don't know	1.0	0.5	0.7
Total	100.0	100.0	100.0
Number	1,918	2,779	4,700

VII. CONCLUSIONS

The 2003 SADHS recorded a substantial decline in fertility in South Africa, from 2.9 births per woman in the 1998 survey to 2.0 in the 2003 SADHS. A more detailed analysis is necessary to explore how much of this decline is real and how much might be due to misreporting. The survey found that the infant and child mortality rates for the five-year period preceding the survey were virtually unchanged from those measured in the 1998 SADHS.

The survey reveals generally high levels of knowledge about HIV and AIDS, with 95 percent of men and 94 percent of women aged 15-49 having heard about AIDS. It seems that the high level of knowledge about HIV and AIDS is starting to translate into behaviour changes. One-third of women aged 15-49 who were sexually active in the 12 months prior to the survey indicated that they used a condom during their last sexual intercourse, compared with 8 percent in 1998.

Levels of knowledge about modern contraception remain high, despite a slight drop, from 97 percent of all women aged 15-49 in 1998 to 94 percent in 2003. An increase in use of modern contraceptive methods was recorded for sexually active women from 61 percent in 1998 to 65 percent in 2003.

High levels of use of primary health care services were recorded for women and children. More than 9 in 10 women who had a birth in the five years preceding the survey reported having received antenatal care from a health professional, mostly from a nurse. The percentage of births that are assisted by a doctor, nurse or midwife increased from 84 percent in 1998 to 92 percent in 2003. Road-to-health cards were available for 68 percent of children aged 12-23 months.

A marked decrease in the prevalence of childhood diarrhoea has been recorded. Overall, this rate has declined from 13 percent of children under five with diarrhea in the two weeks preceding the survey in 1998 to 8 percent in 2003. Especially encouraging is the drop in diarrhoeal disease in children under six months of age (11 percent in 1998 to 6 percent in 2003) and those aged 6-11 months (22 percent in 1998 to 17 percent in 2003).

There has been little change in breastfeeding practices, although there has been a slight increase in the proportion of children 0-3 months who are not being breastfed and a large decrease in the proportion of children who are fed with a bottle with a nipple.

The drop in the proportion of men age 15 and over who smoke daily (from 42 percent in 1998 to 36 percent in 2003) is an indication that the Department of Health's efforts to reduce smoking are succeeding. Another lifestyle indicator that has shown marked improvement is the percentage of adult women who are obese (30 percent in 1998 to 23 percent in 2003).

References

Bradshaw, Debbie and Nadine Nannan. 2004. Health Status. In *South African Health Review 2003/04* (Chapter 4). Durban: Health Systems Trust.

Department of Health, Medical Research Council, and ORC Macro. *South Africa Demographic and Health Survey 1998*. Calverton, Maryland, USA: DOH, MRC and ORC Macro.

Health Systems Trust, 2003. The National Primary Health Care Facilities Survey 2003. Durban: Health Systems Trust.

Shisana, Olive, Leickness Simbayi. 2002. *Nelson Mandela/HSRC Study of HIV/AIDS: South African national HIV prevalence, behavioural risks and mass media household survey 2002.* Cape Town, South Africa: Human Sciences Research Council.

Statistics South Africa (SSA). 2004. Mid-year population estimates, South Africa 2004. Statistical release P0302. Pretoria: SA.

Udjo, Eric. 2003. A Re-examination of Levels and Differential in Fertility in South Africa from Recent Evidence. *Journal of Biosocial Science*, 35:413-431. Cambridge University Press: United Kingdom.

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